State of New Jersey

OFFICE OF THE ATTORNEY GENERAL
DEPARTMENT OF LAW AND PUBLIC SAFETY
STATE ATHLETIC CONTROL BOARD
P.O. BOX 180
TRENTON, NJ 08625-0180

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JEFFREY S. CHIESA
Attorney General

TONY ORLANDO
Chairman

STEVEN KATZ
LEN HEDINGER
Members

AARON M. DAVIS
Commissioner

TO: PROFESSIONAL COMBATIVE SPORTS CONTESTANTS

FM: Aaron M. Davis
Commissioner

RE: NEW JERSEY PROFESSIONAL BOXER/KICKBOXER/MIXED MARTIAL ARTS LICENSE APPLICATION

Enclosed are the annual requirements for application as licensed professional boxer/mixed martial arts/kickboxer contestant in the State of New Jersey.

To be licensed as a **Boxer/Mixed Martial Arts/Kickboxer** contestant, you must submit the following to this office.

1. Completed Application Form
2. Completed Physical Examination - Boxer Form (dated within 6 months of licensure/event)
3. Complete HIV exam (not required to obtain a license, however, to compete in an event, test must be dated within 6 months of event)
4. Complete HEP B Surface AG testing & HEP C AB (not required to obtain a license, however, to complete in an event, test must be dated within 6 moths of event)
5. Complete Blood Count (CBC) and Bleeding & Coagulation (PT/PTT Pro-Time)
6. Original EKG report, read by a physician (dated within 6 months of licensure/event)
7. Original CT/MRI Brain SCAN report (without contrast), read by a physician (dated within 3 years of licensure/event)
8. Original EYE examination by an ophthalmologist - opthalmological dilation (dated within 6 moths of licensure/event)
9. Serum Pregnancy test (dated within 30 days of licensure/event & repeated within 30 days of each event)
10. Annual Physical/Clinical Gynecologial & Breast Exam for women (dated within 30 days of licensure/event)
11. Check or money order in the amount of $5.00, payable to the State Athletic Control Board

TELEPHONE: (609) 292-0317 FAX: (609) 292-3756

NOTE: Proof of medical testing must be provided through **"ORIGINAL DOCUMENTS"** indicating date of test, location of test and identification of the doctor. The date, location and name of doctor who reviews the medical test results must also be provided.

IMPORTANT: The New Jersey Boxer License that you receive will be effective for **Twelve (12)** months from date of issue.

To reduce the costs for individuals tests, the Board has obtained an agreement from Occupational Health, Bridgeton Health Center to provide medical testing at specific rates. For further information contact:

Occupational Health
Bridgeton Health Center,
Ground Floor
333 Irving Avenue
Bridgeton, New Jersey 08302.
Phone: 856.575.4835 (direct phone #)
Fax: 856.453.1218
E-Mail: piercej@sjhs.com

Applicants are reminded: You are subjected to the requirements of the State Athletic Control Board rules, provided by Chapter 46 of the New Jersey's Administrative Code.

Take note of "Subchapter 5 Boxers" under the rules, and the subject of Boxer-Manager contracts within New Jersey New Jersey. Submitting a valid Boxer-Manager contract to this office may avoid possible disputes or court action.

Important: Effective immediately all boxer-manager contracts shall be executed and signed in the presence of the commissioner. In order to have the contract recognized, please schedule an appointment with the commissioner.

If there are any questions regarding your application, please contact this office at 609.292.0317.

A.M.D.

AMD/tg
Enclosure
02.2012

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Commissioner

January 2010

Dear Applicant:

Please be advised that new procedures for obtaining a SACB license are being implemented. Please note and adhere to the directions below.

All application packets must be completed in full and received by New Jersey State Athletic Control Board office no later than 4:00 p.m. two days prior to the event. Application packets will consist of:

- an application
- a digital photo ID (driver's license or passport) e-mailed via jpeg or bitmap format (cannot be faxed)
- a signature in bold pen spanning the width of an 8.5 x 11 sheet of paper
- a digital "head shot" photo (cannot be faxed) and if e-mailed jpeg or bitmap format
- a check or money order covering all fees (made payable to N.J.S.A.C.B.)

Application packets can be submitted by e-mail (SACBLicensing@lps.state.nj.us), US mail, or in person at the Trenton office.

No license will be issued until all requirements are met.

Sincerely,

Aaron M. Davis
Commissioner
SACB

AMD/tg

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****PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.AC.B ***NO CASH!!*****

NEW JERSEY STATE ATHLETIC CONTROL BOARD - LICENSE APPLICATION

P.O. Box 180, Trenton, NJ 08625-0180

Telephone: 609.292.0317 Office Fax: 609.341.5038 Medical Fax: 609.292.3756

SECTION I - All Applicants Complete **Check (✓) or circle Type/s of License**

Last Name:	**CONTESTANT**	**MANAGER**	**SECOND**	**ANNOUNCER ❑ $25**
	Boxer ❑ $5	Boxing ❑ $25	Boxing ❑ $25	**TIMEKEEPER ❑ $25**
	Kickboxer ❑ $5	Kickboxer ❑ $25	Kickboxer ❑ $25	**INSPECTOR ❑ $0**
First Name:	MMA ❑ $5	MMA ❑ $25	MMA ❑ $25	**PHYSICIAN ❑ $0**
	REFEREE	**JUDGE**	**PROMOTER**	**MATCHMAKER**
	Boxing ❑ $75	Boxing ❑ $75	Boxing ❑ $300	Boxing ❑ $100
Middle Name:	Kickboxing ❑ $75	Kickboxing ❑ $75	Kickboxing ❑ $300	Kickboxing ❑ $100
	MMA ❑ $75	MMA ❑ $75	MMA ❑ $300	MMA ❑ $100
	Amateur MMA ❑ $75	Amateur MMA ❑ $75	Amateur MMA ❑ $300	Amateur MMA ❑ $100
AKA or Alias:				

Address:	City:	State:	Zip:	Country:
Mailing Address:	City	State:	Zip	Country

Date of Birth: ____/____/____	Sex: **Male** **Female**	Have you ever been convicted of a crime? If yes, explain: **YES** **NO**
Social Security No. ____/____/____	Height ____ Weight ____	Are you presently on any suspension list? If yes, please explain: **YES** **NO**
Citizenship:	Place of Birth (City/State):	Have you ever been disqualified in any contest or disciplined for your actions during a contest? If yes, please explain: **YES** **NO**
E-Mail:		Has any license you've held been revoked? **YES** **NO** If yes, please explain:
Telephone:(Residence) ( )	Telephone:(Business) ( )	List all other Athletic Commissions in which you are licensed:
Telephone: (Cell) ( )	Fax: ( )	NJSACB Office Use

Section II - Boxer's, Kickboxer's & Mixed Martial Artist Only - Please Print

Have you ever been hospitalized due to an injury suffered in any contest? If YES, please explain **YES** **NO**	Do you have any current medical conditions? **YES** **NO** If YES, please explain.

Have you had amateur experience? **YES** **NO** Amateur Record: _____ Number of Fights: _____

Submission Grappling Record: _____ Name of Gym or Club where you trained: _____

Do you have a **Manager** and/or **Trainer**? **YES** **NO** If yes, provide name

Manager Name: _____ Address: _____ Contact # _____

Trainer Name: _____ Address: _____ Contact# _____

SECTION II (continued) **Fighters Only Communicable Bodily Fluid Virus High-Risk Questionnaire****

1. Do you have any immediate family members who have HIV, Hepatitis B or C? **YES** **NO** If yes, please provide detail.

   _____

2. Have you received a transfusion of blood or blood components? **YES** **NO** If yes, specify date, location, reason

   _____

3. Have you had surgery requiring blood products? **YES** **NO** If yes, specify date, location, reason

   _____

4. Have you used injectable drugs? **YES** **NO** If yes, specify date of most recent injection _____

5. Have you been sexually active with an individual who has HIV, Hepatitis B or C? **YES** **NO** If Yes, please provide most recent date of such activity: _____

6. Have you engaged in unprotected sex? **YES** **NO** If Yes, please provide most recent date of such activity_____

7. Have you had sex with a injectable user? **YES** **NO** If Yes, please provide most recent date of such activity_____

8. Have you worked in a health care or laboratory setting? **YES** **NO** If Yes, please provide appropriate dates:

   _____

9. Have you been imprisoned or worked in a prison or any type of correctional facility: **YES** **NO** If Yes provide appropriate dates: _____

10. Do you have any tattoos or body piercing? **YES** **NO** If Yes, when was most recent one obtained _____

11. Do you have any reason to believe that you may have contracted HIV or Hepatitis B or C at anytime? **YES** **NO**
    If Yes, explain: _____

SECTION III (Manger's and Second's Only) Please Print

List names of fighter/s which you currently manage or second:

_____

Do you know of any medical conditions the above fighter(s) currently have? **Yes** **No** If YES, please explain:

SECTION IV - ALL APPLICANTS MUST COMPLETE THIS SECTION - New Jersey Child Support Certification Process

Please certify, under penalty of perjury, the following::

Yes	No	1) Do you currently have a child support obligation?
Yes	No	1a) If YES, are you in arrears in payment of said obligation?
Yes	No	1b) If "YES", does the arrearage match or exceed the total amount payable for the past six months
Yes	No	2) Have you failed to provide any court ordered health insurance coverage during the past six months
Yes	No	3) Have you failed to respond to a subpoena relating to either paternity or child-support proceeding?
Yes	No	4) Are you the subject of a child-support related arrest warrant?

In accordance with N.J.S.A.2A:17-56.44d, an answer "Yes" to any of the numbered questions 1a through 4 will result in a denial of licensure. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

I THE UNDERSIGNED HEREBY DECLARE THAT I HAVE READ THIS APPLICATION AND THAT ALL THE ANSWERS TO THE QUESTIONS ARE TRUE, AND COMPLETE. I UNDERSTAND THAT ANY MISREPRESENTATION OR FAILURE TO ANSWER SHALL CONSTITUTE GROUNDS FOR LICENSE REVOCATION AND OR OTHER APPLICABLE LEGAL PENALTIES.

I ALSO UNDERSTAND THAT BY SIGNING THIS APPLICATION THAT I AM AUTHORIZING THE STATE ATHLETIC CONTROL BOARD TO CONDUCT A FULL INVESTIGATION INTO MY BACKGROUND AND ACTIVITIES. I UNDERSTAND THAT THE OFFICE OF THE ATTORNEY GENERAL AND THE NEW JERSEY STATE POLICE MAY PARTICIPATE IN THIS BACKGROUND INVESTIGATION.

TO ALL COURTS, PROBATION DEPARTMENTS, SELECTIVE BOARDS, EMPLOYERS, EDUCATION INSTITUTIONS FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH STATE ATHLETIC CONTROL BOARD AND FOR THE PURPOSE OF THIS APPLICATION, YOU ARE HEREBY AUTHORIZED TO RELEASE ANY AND ALL INFORMATION PERTAINING TO ME, DOCUMENTARY OR OTHERWISE, AS REQUESTED BY ANY APPROPRIATE EMPLOYEE, AGENT OR REPRESENTATIVE OF THE STATE ATHLETIC CONTROL BOARD, THE OFFICE OF THE ATTORNEY GENERAL OR THE NEW JERSEY STATE POLICE.

I THE UNDERSIGNED STATE THAT A PHOTOSTATIC OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

FURTHER, I AM AWARE AND AGREE THAT MY SIGNATURE CONSTITUTES A WAIVER OF LIABILITY AS TO THE STATE OF NEW JERSEY AND ITS INSTRUMENTALITIES AND AGENTS FOR ANY DAMAGE RESULTING IN DISCLOSURE OR PUBLICATION IN ANY MANNER, OTHER THAN A WILLFULLY UNLAWFUL DISCLOSURE OR PUBLICATION, OF ANY MATERIAL OR INFORMATION ACQUIRED DURING THE LICENSURE CONSIDERATION PROCESS OR DURING ANY INVESTIGATIONS, INQUIRY OR HEARING.

I HEREBY AUTHORIZE THAT RELEASE OF ANY CRIMINAL HISTORY RECORD INFORMATION TO THIS AGENCY ONLY FOR THE EXPRESS PURPOSE OF PROCESSING MY APPLICATION FOR A LICENSE. THE AUTHORITY TO REQUEST CRIMINAL INFORMATION IS SET FORTH IN THE N.J.S.A.5:2a-15.

I UNDERSTAND THAT THE DISCLOSURE OF MY SOCIAL SECURITY NUMBER ON THIS APPLICATION IS VOLUNTARY AND THAT IT WILL ONLY BE USED FOR PURPOSES OF PROCESSING MY APPLICATION.

PRINT NAME: _____ SIGNATURE: _____ DATE: _____

NEW JERSEY STATE ATHLETIC CONTROL BOARD
P.O. BOX 180 TRENTON NJ 08625
PHONE 609-292-0317 FAX 609-292-3756
PROFESSIONAL COMBATIVE SPORTS CONTESTANT PHYSICAL EXAMINATION

Contestant Name: _____

Street Address: _____ City _____ State _____ Zip _____

Phone: _____ Date of Birth: _____

I certify that I have examined the above named contestant on _____ and have found him/her to be medically cleared to engage in an professional combative sport competition.

Physician Name (printed): _____
Physician Signature: _____

Physician Address: _____ City: _____ State: _____ Zip: _____

Office Phone: _____ Physician's License Number: _____

CONTESTANT EXAMINATION:

Height: _____
Weight: _____
Sex: _____

Blood Pressure: _____
Pulse: _____

Temperature: _____

Blood Type: _____

Allergies:

Medications:

Any enlarged glands:

Ears - Otoscopy:

Mouth Pharynx:

Lungs:

Heart:

Must include check for Murmurs:

Abdomen:

Abdominal Palpation:

Hernias:

Enlargement of Liver:

Enlargement of Spleen:

Testis:

NEUROLOGICAL:

Knee Jerk:

Babinski:

Rhomberg:

Finger to nose:

Gait:

Brudzinski:

Cranial Nerves:

Bicep Jerks:

UPPER EXTREMITIES:

Hands:

Wrist:

Elbows:

Shoulder:

Lower Extremities:

Skin:

Open or Superlative lesions:

Rashes:

Any unhealed cuts:

Any indications of active renal disease:

PHYSICAL HISTORY:

Chest Pains:

Fainting Spells:

Chest Palpitations:

Hemoptysis or Vomiting of Blood

Shortness of Breath

Frequent Headaches:

Convulsions:

Past Head Injury or Concussions:

Operations:

Diabetes:

Unconsciousness from training or competing:

FOR WOMEN:

Pregnancy Test:

Breast Exam:

Gynecological Exam:

PHYSICIAN COMMENTS:

PHYSICAL HISTORY(CONTNUED):

Unconsciousness from any other sport or for any other reason:

Sickle Cell Disease:

Infectious Disease:

DILATED EYE EXAMINATION MUST BE PERFORMED BY AN OPHTHALMOLOGIST

EYES RIGHT LEFT

Distant Vision:

Light Reflex:

Accommodation Reflex:

Fundi:

Cataracts:

Wears Contact Lenses:_____

Has patient had blurred vision?
If yes, please detail:_____

Has patient had surgical procedures done to his/her eyes or the tissues around the eye?
If yes, please detail:_____

Has applicant ever had a retinal tear, retinal detachment, glaucoma, aphakia, or dislocated lens?
If yes, please detail:_____

Does patient have different size pupils?
If yes, please explain:_____

I certify that I have examined the above contestant on _____ and have found nothing in his//her eye examination which would prohibit engaging in an professional combative sport competition.

Ophthalmologist Name (printed)_____
Ophthalmologist Signature:_____

Ophthalmologist Address: _____ City: _____ State: _____
Zip: _____
Office Phone: _____ Physician's License Number:_____

I hereby declare that the foregoing information is true, complete and correct. I understand that any misrepresentation may subject me to license revocation and applicable legal penalties.

Contestant's Signature:_____ **Date:**_____

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AARON M. DAVIS
Commissioner

TO: All Boxers/Mixed Martial Artists/Kickboxers

FROM: Aaron M. Davis, Commissioner, SACB

SUBJECT: Pre-Fight Medicals Questionnaire

DATE: October 2009

Please be advised that all medical questions appearing on SACB pre-fight questionnaires are designed to ascertain information relative to any existing medical condition you may be presently experiencing. If you are currently taking prescribed medication and/or have recently been treated for any injury, you should answer "yes" to the question. Answering "yes" does not automatically mean that you will be disqualified from participating, however, if you fail to honestly disclose the information to us prior to your participation, and it is revealed during the post-fight physical examination or through the drug testing process you will be suspended.

AMD/tg
c: Nicholas Lembo
Ringside Physicians

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Sign your name inside the width of the box with thick black marker (large & bold)

PRINT NAME: _____

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